Supreme Court, U.S.
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No._____

IN THE SUPREME COURT OF THE UNITED STATES

October Term 1994

LOIS LAMB AND CHARLTON LAMB,
PETITIONER - PLAINTIFFS,

V.

VILLAGE OF QUINCY,
RESPONDENT - DEFENDANT.

ON WRIT OF CERTIORARI
TO THE COURT OF APPEALS
FOR LOGAN COUNTY, OHIO
THIRD APPELLATE DISTRICT

NO. CA-93-06-8013

PETITION FOR WRIT OF CERTIORARI OF LOIS LAMB AND CHARLTON LAMB

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10 pp

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Medicare Secondary Payor Act, Medicare Act §1862(b), 42 U.S.C. §1395y(b), (Act) preempts OHIO REV. CODE §2744.05, an Ohio statute which abrogates the Collateral Source Rule in tort cases against political subdivisions by requiring a trial court to reduce a jury verdict by the amount of Medicare benefits paid on behalf of the Plaintiff for medical items and services arising out of the injury giving rise to the suit.

2. Whether OHIO REV. CODE §2744.05 is repugnant to U.S. CONST. amend. XIV as it deprives beneficiaries of Medicare their full rights and privileges provided under the Act.

PARTIES TO THE PROCEEDINGS

The Petitioners, Plaintiffs and Appellants below, are Lois Lamb and Charlton Lamb, husband and wife, from St. Marys, Ohio.

The Respondent, Defendant and Appellee, is the Village of Quincy, a municipal corporation located in Logan County, Ohio.

Because 28 U.S.C. §2403(b) may be applicable, the State of Ohio, represented by Lee Fisher, Attorney General for the State of Ohio, may also be a Respondent in this case.

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OPINIONS BELOW

The opinion of the Court of Common Pleas of Logan County, Ohio, was unreported. The opinion of the Logan County Court of Appeals can be found at *Lamb v. Quincy,* 92 Ohio App. 3d 592, --N.E. 2d-- (Logan Co. 1993). The Ohio Supreme Court overruled Lamb's motion to certify the record at *Lamb v. Quincy,* 69 Ohio St. 3d 1439, 632 N.E.2d 522 (1994) (Table, No. 94-447). These opinions are reprinted in the Appendix to the Petition for Certiorari and appear at pages A-1, A-5, and A-6, respectively.

JURISDICTION

This Court has jurisdiction to review this case under 28 U.S.C. §1257 as (1) the highest court of Ohio which could hear the case has ruled, (2) Petitioners claim a right or privilege under a statute of the United States, (3) Petitioners claim that a law of the State of Ohio is repugnant to the Constitution and the laws of the United States, and (4) all of these issues were argued below.

The Logan County Court of Appeals issued its decision on December 28, 1993. The Petitioner timely filed a Notice of Appeal to the Ohio Supreme Court on January 26, 1994 and filed it with that same court on February 25, 1994. That Court overruled Lambs' Motion to Certify the Record on May 18, 1994. No request for rehearing was made to the Ohio Supreme Court.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED IN THIS CASE

The constitutional and statutory provisions involved in this case and the pages in the Appendix where they appear verbatim are as follows:

U.S. CONST. art. VI A-17

U.S. CONST. amend. XIV. A-17

42 U.S.C. §1395y(b)[1]. Exclusions from coverage and medicare as secondary payer A-18

OHIO REV. CODE §2744.05. Limitations on damages awarded. A-27

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STATEMENT OF THE CASE

In April 1990, as Lois Lamb stepped down from a curb in the Village of Quincy, her foot got caught in a pothole, she tripped, and violently fell to the street, severely injuring her left knee in the process. At the close of a two day trial, the jury returned a verdict of $30,000.00 in Lambs' favor and against the Village. The jury ascribed sixty percent (60%) of the comparative negligence to the Village and forty per cent (40%) to the Lambs. It is not the jury verdict in this case, but, rather, the post verdict modifications to it which give rise to this petition.

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[1]Medicare Secondary Payor provisions of the Medicare Act as found at 42 U.S.C. §1395y(b) shall be referred to as the "Act".

Pursuant to OHIO REV. CODE §2315.19, the Trial Court reduced the verdict from $30,000 to $18,000 in accordance with the comparative negligence percentages. Lambs contended that Quincy was obligated to pay the full $18,000 and that, in turn, Lambs would be obligated under 42 U.S.C. §1395y(b) and 42 C.F.R. §411.24(h) to reimburse Medicare. As such, Medicare would contribute to the "procurement costs" in obtaining the judgment and would permit allocation of the comparative negligence to the $13,573.01 leaving the Lambs a net of approximately $9,856.19 and Medicare approximately $8,143.81 before litigation expenses.

The Trial Court, however, relying on OHIO REV. CODE §2744.05, subtracted the full $13,573.01 (the amount of payment Lamb received from Medicare). This resulted in a net judgment of only $4,426.99 for the Lambs and nothing for the United States of America. However, the money when received by Lambs is due in full to the United States. *See, St. Agnes Hosp. v. Jaeckel*, 616 F. Supp. 426 (D.C. Wis. 1985). The Trial Court tried to dispell this concern by holding Medicare was estopped from bringing a claim against the Lambs or Quincy because Medicare's carrier in Ohio, Nationwide, defaulted on a third party summons.

At this post verdict hearing, and in written argument, Petitioners argued that federal law preempted the state statute. Common Pleas Court Judgment Entry, A-3; [Plaintiffs'] Memorandum at 2-3.

The Lambs appealed this decision to the Court of Appeals for Logan County, Third Appellate District raising three issues: (1) whether the Act preempted OHIO REV. CODE §2744.05; (2) whether HHS was estopped to bring a claim against the Village as a result of Nationwide's (Medicare's carrier in Ohio) failure to answer the third party summons; and (3) in what order should OHIO REV. CODE

§§2744.05 and 2315.19 be applied. Court of Appeals Opinion, A-6.

In that court, the Lambs opined that the 42 U.S.C. §1395y(b) and U. S. CONST. art. VI and amend. XIV controlled in this case, not Ohio law. The Lambs argued that under U.S. CONST. art. VI, Cl. 2, the Act preempted Ohio law (Appeal Brief of Plaintiff-Appellant, pp. 4, 5-7). They further urged that the reduction of the jury award by the amount paid by Medicare violated the Fourteenth Amendment because it deprived Lamb a right under federal law (*Id.*, at 8). They finally urged the Court of Appeals to find that Medicare was not estopped from bringing a claim for damages. (*Id.*, at 9-11).

The Court of Appeals reversed the Trial Court on the issue of estoppel and found that the Act preempted only the anti-subrogation section of OHIO REV. CODE §2744.05. Relying on this Court's decision in *Louisiana Pub. Serv. Comm. v. F.C.C.*, 476 U.S. 355, 368-69 (1986) the Court held that federal law did not prohibit the state from reducing compensation for the torts of its political subdivision by the amounts received from Medicare while in the same opinion it effectively denied the United States ready access to reimbursement for its payments. In essence, it sanctioned the Village's use of Medicare as the primary payor.

It opined that "[b]oth statutes [the Act and OHIO REV. CODE §2744.05] can, and do, exist harmoniously without one doing damage to the other". Court of Appeals Opinion, A-10. It went on to hold that the reduction for Medicare was not preempted.

> Moreover, failure to make the deduction would violate that part of R.C. 2744.05(B) which has not been preempted by federal law. We find no compelling reason or authority to allow appellants to

be the stakeholder of the money which the federal government may require be paid back to Medicare.

Id., at A-12.

On February 25, 1994, the Lambs filed a Motion to Certify the Record in the Ohio Supreme Court. They argued for reversal on the same bases as they did in the Court of Appeals. On May 18, that Court overruled the motion. *Lamb v. Quincy,* 69 Ohio St. 3d 1439, --N.E.2d-- (1994) (Table, No. 94-447) Douglas, J., dissenting. No motion for rehearing was filed.

ARGUMENT

OHIO REV. CODE §2744.05 shifts the primary obligation to pay the costs of medical items and services arising out of political subdivision torts from these subdivisions, where it belongs, to Medicare where Congress has said that primary payment obligation does not belong. By the Act, Congress clearly intended that the United States was to be a secondary payor under Medicare, and that whenever, and wherever, possible, the Secretary of HHS was to obtain full reimbursement from the "primary plan". "Plan" was defined broadly to include the Village in this case. Nevertheless, the Ohio courts have reached a conclusion in direct conflict with its sister states and federal court interpretations of the interplay between the Act and

abrogation of the Collateral Source Rule[2] and other modifications to tort law.

Federal law preempts state law when "it is impossible to comply with both state and federal law. . . ***or [when] the state law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress.***" *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248, 104 S.Ct. 615, 621, 78 L. Ed. 2d 443 (1984). [Emphasis added] *See, also, Ray v. Atlantic Ritchfield Co.*, 435 U.S. 151, 158, 98 S.Ct. 988, 994, 5 L. Ed. 2d 179 (1988). U.S. CONST. art. VI.[3] The full purpose and objective of the Act is to obtain maximum recovery for the United States from those persons otherwise liable.

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[2]The Collateral Source Rule excludes evidence that a tort plaintiff has received compensation for injuries from a third party and prohibits the jury from reducing its verdict by the amount of such compensation. *See*, RESTATEMENT (SECOND) OF TORTS §920A (1979) (defining the Collateral Source Rule).

[3]U.S. CONST. art. VI, Cl. 2. reads:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the Supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

I. The Act constitutes a comprehensive federal scheme to maximize recovery by United States from those otherwise liable to pay for the items and services paid by Medicare.

Medicare is a federal program designed to indemnify the elderly and disabled for the costs of various medical services and items. A beneficiary, of which Lois Lamb is one, for a monthly fee, is entitled to this indemnification.

Since it only reimburses of out of pocket medical expenses, Medicare does not compensate its beneficiaries for non economic losses such as pain and suffering, nor does it compensate for other non-medical economic losses such as lost wages, etc.

Though not universal in its coverage, Medicare has become an enormous social program imposing an onerous burden on the U.S. Treasury. To obviate some of that cost, Congress determined that it was necessary to change Medicare from a primary payor to a secondary payor. In that regard, with the Omnibus Reconciliation Act of 1980, Sec. 953, Pub. L. 96-499, Congress began to amend Medicare to insure that Medicare became, in fact, a secondary, not the primary, payor of benefits. This provision, found at 42 U.S.C. §1395y(b), has evolved into a comprehensive plan which prohibits devices which tend to directly, or indirectly, make Medicare the primary payor.

The first change was to shift the burden of coverage to insurance companies otherwise liable. H. Rep. No. 96-1167, 96th Cong. 2nd Sess., *reprinted in* 1980 U.S. Code, Cong. & Admin. News, 5526, 5752. Shortly after that modification, Congress shifted some end state renal disease expenses to group health plans. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, Sec. 720H, 95 Stat 357 (1981).

Congress shifted even more of the costs to private insurers in the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, 96 Stat. 324 (1982) when it required primary plans to carry the expense of the "working aged" and prohibited group health plans from carving out coverage for those eligible for Medicare.

The Deficit Reduction Act of 1984, Pub.L. 98-369, Sec. 2344(a)(3), 98 Stat. 494, 1095 (1984) granted the United States the right of subrogation to payments made to beneficiaries when other insurance was available and gave the Secretary the right to seek recovery of overpayments from the beneficiary or third parties and to intervene in cases the concerned the events giving rise to the services and items. "These provisions are intended to improve the ability of the medicare program to obtain reimbursement to which it is entitled by law." H.R. Rep. No. 98-432, 98th Cong., 2d Sess., *reprinted in* 1984 U.S. Code, Cong., & Admin. News 697, 1417. Other amendments have been made--all furthering the same Congressional intent that Medicare was to be the secondary payor.

As an integral part in the enforcement of the Secondary Payor Act, the Secretary of HHS has promulgated regulations to further enhance enforcement. 42 C.F.R. §411.21 defines "plan" so as to include the Village's liability to Lamb. At 42 C.F.R. §411.24 the Secretary has identified how he will recover payments made conditionally to beneficiaries. 42 C.F.R. §411.28 provides for waiver of recovery and compromise of claims. Under these regulations the beneficiary, such as Lamb, has the obligation to bring the entire claim. When the beneficiary has obtained payment from the tortfeasor, the Secretary has established regulations for allocating the payments among Medicare and the victim. These include "procurement" (litigation) costs, which are commonly deducted from the reimbursement amount that the beneficiary must pay to

Medicare. 42 U.S.C. §1395(y)(b)(2) and 42 C.F.R. §411.28. The Secretary of H.H.S. may also waive some or all of the payments. 42 C.F.R. §411.31 and §401.613. Among the factors to be considered for the waiver are the age, health and income of the debtor. 42 U.S.C. §1395y(b)(2)(B)(iv); 42 C.F.R. §401.613.

Thus Lamb was required to protect Medicare's interest in any forthcoming settlement or judgment. Once it was received she was obligated to reimburse Medicare for the amount it paid. In this scheme, the liable party cannot deny paying the beneficiary because Medicare has paid the bill. Rather it must pay the beneficiary and it is then the beneficiary's responsibility to pay Medicare. Congress and the Secretary both have recognized that allowing the third party not to pay the claimant on the grounds that Medicare already has paid is a poorly disguised device to avoid paying Medicare all together.

As a beneficiary who has received a third party payment, Mrs. Lamb is required to personally reimburse Medicare, minus procurement costs, within sixty days. 42 C.F.R. §411.24(h). If she fails to complete this task, Medicare has a direct right to recover the reimbursement from her. 42 U.S.C. §1395y(b)(2)(B)(ii); 42 C.F.R. §411.37; *U.S. v. Sosnowski*, 822 F.Supp 570, 572 (W.D. Wisconsin). Therefore, if a state court deducts the collateral source payments from a jury verdict, the plaintiff is exposed to double liability for the Medicare payments it received. For example, although the court deducted the $13,573.01 from Mrs. Lamb's damage award, Mrs. Lamb has not paid Medicare that money. Thus, she may remain liable to Medicare for that amount under 42 U.S.C. §1395y(b)(2)(B)(ii) and 42 C.F.R. §411.37.

Though liable for the full amount received from Medicare, Lamb could ask the Secretary to allocate Medicare's share on a basis other than dollar for dollar.

Since Lamb received only sixty percent (60%) of the verdict, HHS could only require reimbursement of sixty percent (60%) of its claim less its share of litigation costs. In this way Lambs would receive sixty percent (60%) of their non-economic and other out of pocket expenses. Thus:

Judgment	$18,000.00
Less 60% of $13,573.01	8,143.81
Net to Mrs. Lamb	$ 9,856.19

The Secretary can waive payment only so long as the purposes of the Act were met. 42 U.S.C. §1395y(b)(2)(B)(iv). All of this is consistent with the Act. That Lamb would receive some "benefit" by increased net proceeds from judgment is of no import to the Village. After all it owed $18,000.00 to Lamb and the United States combined. How they allocated the receipt is their own affair, not the Village's, and clearly one in which the Ohio General Assembly cannot intervene.

In *Michigan Canners and Freezers Assoc., Inc., v. Agricultural Marketing and Bargaining Bd.*, 467 U.S. 461, 81 L.Ed. 2d 399, 104 S. Ct. 2518 (Mich. 1984) this Court held that the Agricultural Fair Practices Act, 7 U.S.C. §§2301 *et seq.* preempted a Michigan statute that required a producer to be a member of a cooperative against his wishes. Though the AFPA did not expressly state that all state laws were preempted, this Court looked for Congress' purpose for promulgating the AFPA and found that the state law obstructed the effectuation of Congressional intent. Similarly, the Ohio statute in this case has the result of impeding Congress' overriding intention to increase reimbursement for Medicare its conditional payments from the primary plans.

II. OHIO REV. CODE §2744.05 as regards Medicare interferes with the full implementation of the Act and is therefore preempted by the Act.

The Ohio General Assembly in response to claims of an insurance crisis implemented a number of reforms of tort law. It modified the Collateral Source Rule for three classes of tort litigation--general torts, OHIO REV. CODE §2317.45, medical malpractice, OHIO REV. CODE §2307.42, and claims against political subdivisions, OHIO REV. CODE §2744.05.[4]

OHIO REV. CODE §2744.05 requires that

> (B) If a claimant receives or is entitled to receive benefits for injuries or loss allegedly incurred from a policy or policies of insurance or any other source, the benefits shall be disclosed to the court, and the amount of the benefits shall be deducted from any award against a political subdivision recovered by that claimant. No insurer or other person is entitled to bring an action under a subrogation provision in an insurance or other contract against a political subdivision with respect

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[4]The viability of these statutes is somewhat in doubt. The Ohio Supreme Court held that the medical malpractice statute did not violate the Ohio Constitution. *Morris v. Savoy,* 61 Ohio St. 3d 684, 576 N.E.2d 765 (1991). However, in *Sorrell v. Thevenir,* 69 Ohio St. 3d 415, ---- N.E.2d --- (1994) the same court held that Ohio Rev. Code §2317.45 was repugnant to the Ohio Constitution and hinted that its earlier decision in *Morris* is "questionable". *Id.* at Ohio St. 3d 425. It has accepted jurisdiction on a case to determine whether the political subdivision provision is similarly unconstitutional. *Buchman v. Wayne Trace Local School Dist. Bd. of Ed.,* 69 Ohio St. 3d. 1438 (1994).

to such benefits. Nothing in this division shall be construed to limit the rights of a beneficiary under a life insurance policy or the rights of sureties under fidelity or surety bonds.

The sole purpose of this provision was to have other insurers carry part of the cost associated with the torts of political subdivisions in Ohio. First, the victims could not receive payment from the subdivision for amounts already paid by others, and, secondly, those who have paid are foreclosed from bringing their own action against the political subdivision as a subrogee. The two worked hand in hand to shift the subdivision's obligation for its torts irreversibly to third parties such as Medicare. Though the State Court of Appeals correctly held that the antisubrogation aspect of this law does not apply to Medicare (Court of Appeals Opinion, A-12) it failed to recognize that the other aspect also violated the Act.

When the Trial Court reduced Lambs' judgment by the amount of Medicare, it either exposed the Lambs' to a forfeiture of the little they did get to Medicare or effectively kept Medicare from collecting the full amount that it was otherwise due. A trial had been held and the Village was held liable for $18,000. It ostensibly had the wherewithal to pay that judgment. Between Lambs and Medicare, it clearly was obligated to pay that amount of money. Since Medicare has not lost its right of subrogation, holding the money from Lambs who must pay Medicare protects no interest of the state except for the clearly unlawful purpose of hoping to avoid the debt entirely. The Ohio law in this regard relies on the notorious method of "paying" bills - obstruct, object, and avoid, hoping the creditor will despair and disappear. It is not a good faith attempt to pay a lawful obligation.

Such a statute also interferes with Medicare's recovery from primary payors because, instead of relying on claimants and their counsel to recover the funds along with other damages, this requires separate litigation which may not occur. The regulations implicitly recognize that claimants will recover money that the Secretary would otherwise find uneconomical to do. Suit against the HHS and the tortfeasor could result in transfer of a lot of common state actions into overworked federal fora.

Even a separate lawsuit by Medicare to recover results in two lawsuits instead of one, double costs, and all made unnecessary if the Act totally preempts OHIO REV. CODE §2744.05. Besides, in addition to a clear interference with the Act in collection from liable parties, the Ohio law also interferes with Lamb's rights under the Medicare Act.

III. OHIO REV. CODE §2744.05 deprives Lamb of her full rights under Medicare in violation of U.S. CONST. amend. XIV.

OHIO REV. CODE §2744.05 is repugnant to the U.S. CONST. amend. XIV as it deprives Lamb, and other beneficiaries similarly situated, of her rights in accordance with federal law. The reduction in the award damages three property rights that she has in Medicare. First, she has the right of contribution from HHS in procuring the settlement or judgment. 42 C.F.R. §411.37. Second, she has the right to allocate the sixty percent (60%) to the Medicare reimbursement and thus, she receives sixty percent (60%) of her non economic losses. Finally, she can negotiate for a complete waiver on the basis of her age, health and income. 42 U.S.C. §1395y(b)(2)(B)(iv). 42 C.F.R. §401.613. The State denied her all of these in this case.

U.S. CONST. amend. XIV prohibits such deprivation. No act of the state can be a clearer violation of this provision of the Constitution.

Lambs recognize that if this Court agrees with them on the issue of pre-emption, it is unnecessary to address this issue. However, this issue further illustrates that Ohio's present effort to conserve the resources of its political subdivisions can only succeed by taking money from Medicare and its beneficiaries--all in violation of federal law and policy.

IV. This Court should hear this case in order to resolve conflicts between the decisional law in Ohio and federal courts.

The Ohio court decision conflicts with the decisions of all federal and state courts which have considered whether state Collateral Source Rule modifications, or other similar insurance and liability laws, are preempted by the Act. Federal Courts considering preemption by the Act have universally held that the Act preempts state abrogation of the Collateral Source Rule and other cost shifting devices. *Abrams v. Heckler,* 582 F. Supp. 1155 (S.D.N.Y. 1984) (New York's no-fault automobile insurance was preempted by the Act); *Smith v. Travelers Indem. Co.,* 763 F. Supp. 554 (M.D. Fla. 1989) (Florida's collateral source law, which was similar to Ohio's, was preempted by Medicare); *Varacalli v. State Farm Mut. Auto. Ins. Co.,* 763 F. Supp. 205 (E.D. Mich. 1990) (no-fault insurance law that required insurers to give discounted premiums to those who could use Medicare for the primary insurance rather than the private insurer held invalid). *St. Agnes Hosp. v. Jaeckel,* 616 F. Supp. 426 (D.C. Wis. 1985) (Medicare preempted Wisconsin law which required proration of insufficient

judgments among the victim and her subrogee); *United States v. Geier,* 816 F. Supp. 1332 (W.D. Wisc. 1993) (Subrogation rights of Medicare took priority over all other rights of recovery); *Blue Cross and Blue Shield Assoc. v. Sullivan,* 794 F. Supp. 1166 (D.C. D.C. 1992) (Regulations to enforce the Act in collecting from insurance companies otherwise liable under contract are valid).

Sister states have recognized the supremacy of the Act. In *American Risk Asssurance Company v. Benrube,* 407 So. 2d 993 (Fla. Ct. of App 1981) that court recognized that Medicare was to be a secondary payor. Similarly, the Pennsylvania courts have held that no fault insurance was primary to Medicare. *Collins v. Allstate Indemnity Company,* 426 Pa. Super. 197, 626 A. 2d 1162 (1993).

As the most recent reported decision on the issue, this case as decided by the Ohio court of appeals will send a false signal that the Act is not as all encompassing as Congress and other courts have said. That is not good law.

Ohio is not the only state to make some modification to the Collateral Source Rule. Other states have modified it. *See, e.g.,* DEL. CODE ANN. tit 18, §6862 (1974); FLA. STAT. ANN. §627.353 (West 1975), IDAHO CODE §§39-4201 to 4210 (1977), IND. CODE ANN. §16-9.5-2-2(b) (Burns Supp. 1975); N.H. REV. STAT. ANN. §507-C:7 I (Supp. 1979); N.Y. CIV. PRAC. L & R. 4010 (1977) These states possess no unusual circumstances that would give rise to these statutes in these particular states, but not their sisters. The potential is there for further encroachment on Medicare's status as a secondary payor.

Medicare is an enormous federal program that taxes the public purse. It must not be subject to fiscal attack by state legislatures who seek to protect the resources of their subdivisions by schemes and devices designed to aid their avoidance of obligations to the victims of their torts and to the United States.

CONCLUSION

Congress by promulgating the Act has shown a clear federal policy and an intent not to allow interference with that scheme by state laws. OHIO REV. CODE §2744.05 interferes with federal law when it requires the deduction of Medicare payments from jury awards against political subdivisions and deprives beneficiaries to right to have Medicare waive some of its rights. Federal law preempts the state from enforcing such legislation. Because Ohio is expressing a conflicting view of the law, it is most appropriate for this Court to grant the writ and accept this case to issue decisional law that will clearly enforce the intent of Congress in enacting the Act.

WHEREFORE, for the foregoing reasons, the Lambs respectfully request that this Court issue a writ certiorari to the Logan County Court of Appeals and rule this important national issue.

Respectfully submitted,
BENJAMIN F. YALE & ASSOCIATES, CO.

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JUDGMENT ENTRY
COMMON PLEAS COURT

IN THE COMMON PLEAS COURT
OF LOGAN COUNTY, OHIO

LOIS LAMB, et al.,	*	
Plaintiff,	*	**Case No. CV92-04-0060**
vs.	*	
VILLAGE OF QUINCY,	*	
Defendant.	*	

JUDGMENT ENTRY

This matter was tried to a jury on April 20 and 21, 1993. The jury in its unanimous verdict found that the Plaintiff had been damaged in the amount of $30,000.00, but that the Plaintiff had been forty percent (40%) negligent. The Court further assigned this matter for a hearing on post-verdict motions for June 1, 1993. The Plaintiff, in her memorandum, raised two issues; Plaintiff contends she is entitled to pre-judgment interest and the memoranda discusses the reduction of the judgment by amount of the collateral benefits received by the Plaintiff. Regarding pre-judgment interest, Defendant requested additional time to respond. However, the Court believes that the law on this subject is fairly straightforward and that under the facts of this case, the Plaintiff should not be entitled to pre-judgment interest. The leading case on pre-judgment interest is *Kalain vs. Smith* (1986) 25 Ohio St. 3rd 157; the syllabus provides:

> "A party has not 'failed to make a good faith effort to settle' under R.C. 1343.03(C) if he has (1) fully cooperated in discovery proceedings, (2) rationally evaluated his risk and potential liability, (3) not attempted to unnecessarily delay any of the proceedings, and (4) made a good faith monetary settlement offer or responded in good faith to an offer from the other party. If a party has a good faith, objectively reasonable belief that he has no liability, he need not make a monetary settlement offer."

This syllabus still appears to be the law of the state and has recently been cited and relied upon by the Court of Appeals for the 3rd District in *Copp vs. Clagg* (1990, 3rd Dist.) 66 OA 3rd 213. A review of this file shows that the Plaintiff is not entitled to pre-judgment interest. Following the syllabus quoted above, there appears no lack of cooperation in discovery proceedings. There are no motions to compel discovery nor motions for continuance because of failure to make discovery or for any reason.

Defendant, in its pre-trial brief filed March 10, 1993, stated that no settlement seemed possible as the Defendant contested negligence and due to a lack of causation. As mentioned above, the jury ultimately determined the Plaintiff was 40% negligent; the Court therefore finds the Defendant had a good faith, objectively reasonable belief that it had no liability. Accordingly, the Defendant's lack of a pre-trial monetary settlement offer in this case should not subject it to pre-judgment interest. As Plaintiff acknowledged in the arguments on these motions, Defendant did offer $5,000.00 during trial to settle this matter.

The Court finds that the Motion for Pre-Judgment Interest is NOT WELL TAKEN. It is ORDERED that the Motion for Pre-Judgment interest be, and hereby is DENIED.

Both the Defendant and Plaintiff raise in their memorandum the issue of the setoff of collateral benefit received. Based upon documents subpoenaed and produced by the United

States Attorney, and counsels' agreement as to which payments were applicable to this accident, the Court finds the Plaintiff received collateral benefits to pay her medical expenses in the amount of $13,573.01. As required by Section 2744.05(B) O.R.C., that amount is hereby deducted "from any award against a political subdivision". Since the Plaintiff was found 40% negligent and the assessment of damages were $30,000.00, the award would be $18,000.00. Accordingly, the collateral benefits adjustment should be made after damages were reduced by the Plaintiff's comparative negligence. *Jeffers vs. Phillips Ready Mix* (1991) 72 Ohio App. 3d 62. The mathematics would be expressed as follows:

$30,000 - ($30,000 x 40% = $12,000) - $13,573.01 = $4,426.99

Plaintiff argues that she should not be subject to the setoff for Medicare because she is still subject to a subrogation type claim from the United States government. However, the Court notes in this case that the Defendant moved to join Medicare and the third-party-payor Nationwide, that the Court ordered the joinder and that the third-party-payor was in fact served. No answer was forthcoming. The Court now finds the third-party-payor and Medicare are estopped from seeking reimbursement from the Plaintiff.

It is, therefore ORDERED, DECREED and ADJUDGED that the Plaintiff be, and hereby is awarded judgment against the Defendant in the amount of $4,426.99. The Court further taxes as cost, the Plaintiff's expenses for taking the deposition of Homayoun Mesgahli, M.D. Costs are hereby assessed against the Defendant.

s/Mark S. O'Connor
Mark S. O'Connor, Judge

cc: Benjamin F. Yale
Jack L. Neuenschwander
File Stamped by the Clerk: June 3, 1993

JOURNAL ENTRY
COURT OF APPEALS

IN THE COURT OF APPEALS OF THE THIRD APPELLATE JUDICIAL DISTRICT OF OHIO LOGAN COUNTY

LOIS LAMB, et al., : CA93-06-8013

Plaintiffs-Appellants : CASE NO. 8-93-13

v. :

VILLAGE OF QUINCY, :

Defendant-Appellee :

JOURNAL ENTRY

For the reasons stated in the opinion of this Court rendered herein on December 28, 1993, the assignments of error are overruled, and it is the judgment and order of this Court that the judgment of the Court of Common Pleas of Logan County is affirmed at the costs of the appellants for which judgment is rendered and that the cause be remanded to that court for execution.

It is further ordered that the Clerk of this Court certify a copy of this judgment to that court as the mandate prescribed by Appellate Rule 27 or by any other provision of law, and also furnish a copy of any opinion filed concurrently herewith directly to the trial judge.

s/John R. Evans

s/Ronald E. Hadley

s/Thomas F. Bryant

JUDGES
DATED: December 28, 1993.

Lamb v. Quincy, 92 Ohio App. 3d 592 (Logan Co. 1993)

92 Ohio App. 3d 592
--N.E.2d--
1993 WL 542488, Lamb v. Village of Quincy, (Ohio App. 3 Dist. 1993)
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Lois LAMB, et al., Plaintiffs-Appellants,
v.
VILLAGE OF QUINCY, Defendant-Appellee.

No. 8-93-13.
Court of Appeals of Ohio, Logan County.
Dec. 28, 1993.

Civil Appeal from Common Pleas Court.

Benjamin F. Yale, Waynesfield, for plaintiffs-appellants.

McCulloch, Felger, Fite & Gutmann Co., L.P.A., Jack L. Neuenschwander, Piqua, for defendant-appellee.

OPINION

EVANS, Presiding Judge.

This is an appeal by Lois and Carlton Lamb from a judgment of the Court of Common Pleas of Logan County contesting the court's calculation of a damage award granted to them after they prevailed in a jury trial.

On April 4, 1990, Mrs. Lamb was in the Village of Quincy when she stepped off the curb and into a hole in the street causing her to fall and be injured. Approximately two years later, she and her husband filed a complaint against Quincy alleging negligence in the maintenance of the street. The case proceeded to a jury trial and on April 21, 1993, the jury determined the Lambs had sustained $30,000 in damages. The jury apportioned the negligence, finding Quincy to have been sixty percent at fault in causing the harm and Mrs. Lamb to have been forty percent at fault. The trial court reduced the jury verdict by forty percent, resulting in an award of $18,000. The court then determined Mrs. Lamb had received $13,573.01 from Medicare and, pursuant to R.C. 2744.05, deducted this amount from the award against Quincy, entitling the Lambs to a final judgment of $4,426.99.

The Lambs challenge the court's determination of their award by asserting three assignments of error, the first of which reads:

The trial court erred when it reduced the jury's verdict by the amount of reimbursements for medical bills received by Lois Lamb under Medicare pursuant to Ohio Revised Code Sec. 2744.05.

Appellants contend the trial court's reduction of their award by the $13,573.01 paid out by Medicare effectively made Medicare the primary payer for her injuries and violated Section 1395y(b)(2), Title 42, U.S.Code which intends for Medicare to be only a secondary payer. Appellants argue that the federal statute pre-empts section 2744.05(B) of Ohio's Revised Code. We disagree with appellants' basic premise. The action of the trial court makes Medicare the primary payer only if Medicare can not recover the funds from the tortfeasor.

The Supremacy Clause of Article VI of the federal Constitution provides Congress with the power to pre-empt state law. Instances when pre-emption occurs were identified by the Supreme Court in Louisiana Pub. Serv. Comm. v. F.C.C. (1986), 476 U.S. 355, 368-69:

* * * Pre-emption occurs when Congress, in enacting a federal statute, expresses a clear intent to pre-empt state law, when there is outright or actual conflict between federal and state law, where compliance with both federal and state law is in effect physically impossible, where there is implicit in federal law a barrier to state regulation, where Congress has legislated comprehensively, thus occupying an entire field of regulation and leaving no room for the States to supplement federal law, or where the state law stands as an obstacle to the accomplishment and execution of the full objectives of Congress. Pre-emption may result not only from action taken by Congress itself; a federal agency acting within the scope of its congressionally delegated authority may pre-empt state regulation. (Citations omitted).

In reviewing appellants' argument that R.C. 2744.05(B) is pre-empted by Section 1395y(b)(2), Title 42, U.S.Code we must consider several aspects of Ohio's statute.

A.

History and Purpose of R.C. 2744.05

In Haverlack v. Portage Homes, Inc. (1982), 2 Ohio St.3d 26, the Supreme Court of Ohio abolished the judicially created doctrine of sovereign immunity in the absence of any statutory provisions enacted to limit the liability of municipal corporations. Subsequently, the General Assembly adopted R.C. Chapter 2744 providing the statutory framework for the liability of political subdivisions. R.C. 2744.02 provides that a political subdivision may be held civilly liable for personal injuries caused by an act or omission of the political subdivision. This section, however, is

specifically made subject to the immunities set forth in R.C. 2744.05 which provides in pertinent part:

Notwithstanding any other provision of the Revised Code or rules of a court to the contrary, in an action against a political subdivision to recover damages for injury, death, or loss to persons or property caused by an act or omission in connection with a governmental or proprietary function:

* * *
* * *

(B) If a claimant receives or is entitled to receive benefits for injuries or loss allegedly incurred from a policy or policies of insurance or any other source, the benefits shall be disclosed to the court, and the amount of the benefits shall be deducted from any award against a political subdivision recovered by that claimant. No insurer or other person is entitled to bring an action under a subrogation provision in an insurance or other contract against a political subdivision with respect to such benefits. * * *

Essentially, R.C. 2744.05(B) provides for two things when an action is brought against a political subdivision to recover for injury, death, or loss to persons or property. First, the collateral source rule is abrogated as to the political subdivision. (FN1) The clear language of the statute requires the court to deduct the collateral benefits from the award recovered by the plaintiff. This conserves the fiscal resources of political subdivisions by providing the protection of sovereign immunity when a person injured by the negligence of the political subdivision is compensated by insurance or some other source of reimbursement. Menefee v. Queen City Metro (1990), 49 Ohio St.3d 27, 29. The statute limits the recovery of injured parties to the amount of the award which has not been paid by other sources. Second, R.C. 2744.05(B) abolishes the insurer's right of subrogation against the political subdivision. Thus, a governmental tortfeasor is liable to pay the injured party only the

amount not covered by insurance or some other source, and insurers are not permitted to recover the money paid to an insured by asserting subrogation rights against the governmental entity. Grange Mut. Cas. Co. v. Columbus (1989), 49 Ohio App.3d 50, 53.

B.

No Pre-emption of Ohio's Abrogation of the Collateral Source Rule

Congress enacted the Medicare Secondary Payer Statute in an effort to reduce federal spending and to protect the financial well being of the Medicare program by requiring that Medicare payments be secondary to all other sources of compensation. Blue Cross & Blue Shield Assn. v. Sullivan (D.D.C.1992), 794 F.Supp. 1166, 1168-69. This statute has subsequently been amended numerous times to expand the extent to which Medicare is made a secondary payer. For example, the Omnibus Reconciliation Act of 1980 (Section 953, Pub.L. 96-499) amended this statute to make Medicare payments secondary to automobile, liability and no-fault insurance. Id.

The amended portion of Section 1395y(b)(2)(A), Title 42, U.S.Code, which pertains to collateral sources, reads:

Payment under this subchapter [Medicare] may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made promptly * * * under a workmen's compensation law or plan of the United States or a State or under an automobile or

liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

We do not find this federal statute to pre-empt Ohio's abrogation of the collateral source rule in suits against political subdivisions. Congress did not expressly state an intent to pre-empt state law, nor does Ohio's law interfere with an application of this portion of the federal statute. Both statutes can, and do, exist harmoniously without one doing damage to the other.

By reducing the award against the village, the trial court complied with R.C. 2744.05(B) and its intent to conserve the fiscal resources of political subdivisions. The congressional objective of Medicare being only a secondary payer was not harmed by this set-off.

C.

Pre-emption of Ohio's Abrogation of an Insurer's Right to Subrogation

The second part of R.C. 2744.05(B) prevents insurers from asserting subrogation rights against governmental tortfeasors. Grange Mut. Cas. Co. v. Columbus (1989), 49 Ohio App.3d 50, 53. This preclusion, however, is contrary to the statutory right of the federal government to be subrogated to the rights of an individual who received Medicare benefits as compensation for a tortious injury caused by some third party.

Section 1395y(b)(2)(B)(i), Title 42, U.S.Code provides that when payment for an injury can be made under a worker's compensation plan or under an automobile or liability insurance policy, Medicare payments are conditional upon reimbursement to the federal government. Section 1395y(b)(2)(B)(ii), Title 42, U.S.Code authorizes the United States to recover Medicare payments by bringing an action against "any entity" which is required or responsible to pay under a primary plan. Section 2651(a), Title 42, U.S.Code authorizes the federal government to

bring an independent cause of action against tortfeasors such as the Village of Quincy. (FN2) This statute states in part:

In any case in which the United States is authorized or required by law to furnish hospital, medical, surgical, or dental care and treatment * * * to a person who is injured * * * under circumstances creating a tort liability upon some third person * * * to pay damages therefor, the United States shall have a right to recover from said third person the reasonable value of the care and treatment so furnished or to be furnished and shall, as to this right be subrogated to any right or claim that the injured or diseased person * * * has against such third person * * *.

Because these statutes and regulations specifically provide for the federal government to be subrogated to any right or claim that an injured party may assert against a tortfeasor, we conclude that the portion of R.C. 2744.05(B) abrogating the subrogation rights of insurers against political subdivisions has been pre-empted by the federal government's statutory right to seek reimbursement for Medicare benefits received by the injured party. This holding leaves R.C. 2744.05(B) intact as against private insurers. However, in order to comply with the congressional intent of allowing the federal government to bring an action against third party tortfeasors for reimbursement of Medicare benefits, the federal law must prevail. There is no provision in the federal law to prevent the federal government from collecting against a political subdivision of a state.

Although we agree with appellants' argument that R.C. 2744.05(B) is pre-empted, insofar as it affects the subrogation rights of the federal government, we do not find the trial court to have erred by reducing the jury's verdict by the amount which may have to be reimbursed to the federal government. Failure to deduct the amount paid by Medicare makes both Medicare and Quincy primary payers should the federal government decide not to enforce its subrogation rights. This is the result which R.C. 2744.05(B) and Section 1395y(b)(2), Title 42, U.S.Code were

specifically intended to avoid. Moreover, failure to make the deduction would violate that part of R.C. 2744.05(B) which has not been pre-empted by federal law. We find no compelling reason or authority to allow appellants to be the stakeholder of the money which the federal government may require be paid back to Medicare.

Appellants' first assignment of error is overruled.

Appellants' second assignment of error states:

The trial court erred when it held that the United States government was estopped from bringing any claim for reimbursement from the tortfeasor for the injuries of Lois Lamb due to a failure of Nationwide Insurance to answer a third party complaint.

Appellants argued to the trial court that the reduction in the award was inappropriate because they were subject to a claim for subrogation by the federal government. The trial court disagreed, noting that Medicare and its third-party-payer, Nationwide, were joined as parties to the action but failed to answer. The court, therefore, found that Medicare is estopped from seeking reimbursement from appellants. We disagree with the trial court's conclusion.

In response to a motion by appellee, the trial court entered an order joining "MEDICARE/Nationwide Mutual Insurance Company" as a party to the action. (FN3) However, Section 421.5(b), Title 42, C.F.R., indicates that the Health Care Financing Administration ("HCFA"), an agency of the Department of Health and Human Services ("HHS"), is the real party in interest in any litigation involving the administration of the Medicare Act. U.S. v. Sosnowski (W.D.Wis.1993), 822 F.Supp. 570, 573. There is nothing in the record to indicate proper service was made upon the federal government. Notice of the joinder and a copy of the complaint were sent by the court to

MEDICARE/Nationwide Mutual Insurance Company. This, however, is not the same as providing notice to HCFA, the Secretary of HHS, or the United States Attorney General and the United States attorney for the district in which the action was brought. Therefore, the federal government was not properly joined as a party and the trial court erred by finding it estopped from seeking reimbursement for the funds paid out by Medicare on the grounds that Medicare had been made a party to this action.

Moreover, estoppel is generally not available against the federal government. See, e.g. Schweiker v. Hansen (1981), 450 U.S. 785. The Seventh Circuit Court of Appeals has identified several factors that must be established before the government is estopped from asserting its rights:

First, the party to be estopped must know the facts. Second, this party must intend that his conduct shall be acted upon, or must so act that the party asserting estoppel has a right to believe it is so intended. Third, the party asserting estoppel must have been ignorant of the facts. Finally, the party asserting estoppel must reasonably rely on the other's conduct to his substantial injury.

Woodstock/Kenosha Health Ctr. v. Schweiker (C.A.7, 1983), 713 F.2d 285, 290, citing Portmann v. United States (C.A.7, 1982), 674 F.2d 1155, 1167. The Sixth Circuit, while reciting the rule that estoppel is not available against the government, appears to also require some "affirmative misconduct" by the government which threatens to work a serious injustice. Giles v. Carlin (E.D.Mich.1986), 641 F.Supp. 629, 639, citing Housing Auth. of Elliot Cty. v. Bergland (C.A.6, 1984), 749 F.2d 1184, 1190.

Under the facts of the instant case, we conclude estoppel against the government would not apply. The elements identified in Woodstock/Kenosha have not been established nor does it appear that all of them could be successfully demonstrated. There, likewise, has been no showing of affirmative misconduct by the government.

Appellants' second assignment of error is well taken to the extent that the federal government is not estopped from asserting its rights for reimbursement of the funds paid by Medicare. This, however, does not mean the damage award was not subject to a reduction pursuant to 2744.05(B).

Appellants' final assignment of error reads:

The trial court erred when it allocated the comparative negligence percentages (Ohio Rev.Code Sec. 2315.19) before deducting collateral sources. (Ohio Rev.Code Sec. 2744.05).

Appellants argue that the collateral benefits paid by Medicare should be subtracted from the $30,000 award assessed by the jury before factoring in the comparative negligence. We disagree.

R.C. 2315.19(B)(4) requires the jury to assess total damages and determine each party's percentage of negligence. The trial court is then required to diminish the total amount of the compensatory damages that would have been recoverable by an amount that is proportionately equal to the percentage of negligence that is attributable to the complainant. R.C. 2315.19(C). This provides the award against the political subdivision which may be recovered by the claimant. Then, the court must deduct the benefits received by the complainant from insurance or any other source as required by R.C. 2744.05(B). Failure to follow this procedure contravenes the legislative intent of R.C. 2744.05(B) to conserve fiscal resources of political subdivisions. (FN4)

Appellants also argue that the portion of Mrs. Lamb's award intended to compensate her for pain and suffering was improperly reduced by the court's applying the comparative negligence percentages before subtracting the collateral benefits. Even if this court were to accept appellants' argument, there is no way to isolate the amount awarded for pain and suffering to permit an application of appellants' theory. There is nothing in the record to show how much of the award was intended by the jury as

compensation for pain and suffering versus medical expenses or Mr. Lamb's claim for loss of consortium.

Appellants' third assignment of error is overruled.

Having found no error prejudicial to the appellants herein, in any of the particulars assigned and argued, the judgment of the trial court is affirmed.

Judgment affirmed.

BRYANT and HADLEY, JJ., concur.

FN1. Under the judicially created collateral source rule, a plaintiff's receipt of collateral benefits is deemed immaterial on the issue of damages. The receipt of such benefits is not to be admitted into evidence, nor is the amount of such benefits to be deducted from the plaintiff's damage award. Mitchel v. Borton (1990), 70 Ohio App.3d 141, 145-46 citing Pryor v. Webber (1970), 23 Ohio St.2d 104.

FN2. Sections 411.24(e) and 411.26(a), Title 42, C.F.R. also provide that the Health Care Financing Administration has a direct right of action to recover Medicare benefits from any entity responsible for making primary payments and is subrogated to any individual entitled to payment from a third party tortfeasor.

FN3. HCFA does not process and pay Medicare claims, but rather contracts with private insurance companies to do so. See Sections 1395h and 1395u, Title 42, U.S.Code. Nationwide Mutual Insurance Company was the intermediary through which Medicare made payments to Mrs. Lamb's health care providers.

FN4. This interpretation is in accord with the holding in Jeffers v. Phillips Ready Mix (1991), 72 Ohio App.3d 62, where the Court

of Appeals for Greene County interpreted R.C. 2317.45(B) and found that collateral benefits were properly deducted from the compensatory damages assessed by the jury after the trial court reduced the damages by the percentage of the plaintiff's comparative negligence.

ENTRY
SUPREME COURT OF OHIO

THE SUPREME COURT OF OHIO

1994 TERM

To wit: May 18, 1994

LOIS LAMB, et al.,:
Appellants,:Case No. 94-447
vs.:E N T R Y

VILLAGE OF QUINCY,:
Appellee.:

Upon consideration of the motion for an order directing the Court of Appeals for Logan County to certify its record, it is ordered by the Court that said motion is overruled.

COSTS:

Motion fee, $40.00, paid by Benjamin F. Yale & Assoc. Co., L.P.A.

(Court of Appeals No. 89313)

s/Thomas J. Moyer
THOMAS J. MOYER
Chief Justice

U.S. CONST. art. VI

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the Supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

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U.S. CONST. amend. XIV.

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Section 2. Representatives shall be apportioned among the several States according to their respective numbers, counting the whole number of persons in each State, excluding Indians not taxed. But when the right to vote at any election for the choice of electors for President and Vice President of the United States, Representatives in Congress, the Executive and Judicial officers of a State, or the members of the Legislature thereof, is denied to any of the male inhabitants of such State, being twenty-one years of age, and citizens of the United States, or in any way abridged, except for participation in rebellion, or other crime, the basis of representation therein shall be reduced in the proportion which the number of such male citizens shall bear to the whole number of male citizens twenty-one years of age in such State.

Section 3. No person shall be a Senator or Representative in Congress, or elector of President and Vice President, or hold any office, civil or military, under the United States, or under any State, who, having previously taken an oath, as a member of Congress, or as an officer of the United States, or as a member of any State legislature, or as an executive or judicial officer of any State, to support the Constitution of the United States, shall have engaged in insurrection or rebellion against the same, or given aid or comfort to the enemies thereof. But Congress may by a vote of two-thirds of each House, remove such disability.

Section 4. The validity of the public debt of the United States, authorized by law, including debts incurred for payment of pensions and bounties for services in suppressing insurrection or rebellion, shall not be questioned. But neither the United States nor any State shall assume or pay any debt or obligation incurred in aid of insurrection or rebellion against the United States, or any claim for the loss or emancipation of any slave; but all such debts, obligations and claims shall be held illegal and void.

Section 5. The Congress shall have power to enforce, by appropriate legislation, the provisions of this article.

42 U.S.C. §1395y(b). Exclusions from coverage and medicare as secondary payer

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan--

(I) may not take into account, for any item or service furnished to an individual 65 years of age or older at the time the individual is covered under the plan by reason of the current employment of the individual (or the individual's spouse), that the individual is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any employee age 65 or older, and any employee's spouse age 65 or older, shall be entitled to the same benefits under the plan under the same conditions as any employee, and the spouse of such employee, under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is sponsored by or contributed to by an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of employment with an employer that does not have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 426-1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of Title 26.

(B) Disabled active individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iv)(II)) may not take into account that an active individual (as defined in clause (iv)(I)) is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 426-1 of this title.

(iii) Sunset

Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before October 1, 1995.

(iv) Definitions

In this subparagraph:

(I) Active individual

The term "active individual" means an employee (as may be defined in regulations), the employer, self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any of such persons.

(II) Large group health plan

The term "large group health plan" has the meaning given such term in section 5000(b)(2) of Title 26.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))--
(i) may not take into account that an individual is entitled to benefits under this subchapter solely by reason of section 426-1 of this title during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426-1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426-1 of this title if the individual had filed an application for such benefits; and
(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from taking into account that an individual is entitled to benefits under this subchapter solely by reason of section 426-1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and on or before January 1, 1996, [FN2PP] (with respect to periods beginning on or after February 1, 1990), clauses (i) and (ii) shall be applied by substituting "18-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered

employment only by virtue of an election made by the religious order under section 3121(r) of Title 26.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

(B) Conditional payment

(i) Primary plans

Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph.

(ii) Action by United States

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

(iii) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(iv) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of Title 26.

(C) Prohibition of financial incentives not to enroll in a group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)), unless such incentive is also offered to all individuals who are eligible for coverage under the plan. Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but--

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed--

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost

(or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis--

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of Title 26) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Health Care Financing Administration shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of Title 26.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for the purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of Title 26 by a qualified employer (as defined in section 6103(l)(12)(D)(iii) of such title), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(iii) Sunset on requirement

Clause (ii) shall not apply to inquiries made after September 30, 1995.

Ohio Rev. Code §2744.05. Limitations on damages awarded.

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Notwithstanding any other provisions of the Revised Code or rules of a court to the contrary, in an action against a political subdivision to recover damages for injury, death, or loss to persons or property caused by an act or omission in connection with a governmental or proprietary function:

(A) Punitive or exemplary damages shall not be awarded;

(B) If a claimant receives or is entitled to receive benefits for injuries or loss allegedly incurred from a policy or policies of insurance or any other source, the benefits shall be disclosed to the court, and the amount of the benefits shall be deducted from any award against a political subdivision recovered by that claimant. No insurer or other person is entitled to bring an action under a subrogation provision in an insurance or other contract against a political subdivision with respect to such benefits. Nothing in this division shall be construed to limit the rights of a beneficiary under a life insurance policy or the rights of sureties under fidelity or surety bonds.

(C)(1) There shall not be any limitation on compensatory damages that represent the actual loss of the person who is awarded the damages. However, except in wrongful death actions brought pursuant to Chapter 2125. of the Revised Code, damages that arise from the same cause of action, transaction or occurrence, or series of transactions or occurrences and that do not represent the actual loss of the person who is awarded the damages shall not exceed two hundred fifty thousand dollars in favor of any one person. The limitation on damages that do not represent the actual loss of the person who is awarded the damages provided in this division does not apply to court costs that are awarded to a plaintiff, or to interest on a judgment

rendered in favor of a plaintiff, in an action against a political subdivision.

(2) As used in this division, "the actual loss of the person who is awarded the damages" includes all of the following:

(a) All wages, salaries, or other compensation lost by the person injured as a result of the injury, including wages, salaries, or other compensation lost as of the date of a judgment and future expected lost earnings of such a person;

(b) All expenditures of the person injured or another person on his behalf for medical care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations that were necessary because of the injury;

(c) All expenditures to be incurred in the future, as determined by the court, by the person injured or another person on his behalf for medical care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations that will be necessary because of the injury;

(d) All expenditures of a person whose property was injured or destroyed or of another person on his behalf in order to repair or replace the property that was injured or destroyed;

(e) All expenditures of the person injured or whose property was injured or destroyed or of another person on his behalf in relation to the actual preparation or presentation of the person's claim;

(f) Any other expenditures of the person injured or whose property was injured or destroyed or of another person on his behalf that the court determines represent an actual loss experienced because of the personal or property injury or property loss.

"The actual loss of the person who is awarded the damages" does not include any fees paid or owed to an attorney for any services rendered in relation to a personal or property injury or property loss, and does not include any damages awarded for pain and suffering, for the loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education of the person injured, for mental anguish, or for any other intangible loss.

Ohio Rev. Code §2315.19. Effect of contributory negligence or implied assumption of risk.

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(A)(1) Contributory negligence or implied assumption of the risk of the complainant or of the person for whom the complainant is legal representative may be asserted as an affirmative defense to a negligence claim.

(2) Contributory negligence or implied assumption of the risk of a person does not bar the person or his legal representative as complainant from recovering damages that have directly and proximately resulted from the negligence of one or more other persons, if the contributory negligence or implied assumption of the risk of the complainant or of the person for whom he is legal representative was no greater than the combined negligence of all other persons from whom the complainant seeks recovery. However, any compensatory damages recoverable by the complainant shall be diminished by an amount that is proportionately equal to the percentage of negligence or implied assumption of the risk of the complainant or of the person for whom he is legal representative, which percentage is determined pursuant to division (B) of this section. This section does not apply to actions described in section 4113.03 of the Revised Code.

(B) If contributory negligence or implied assumption of the risk is asserted and established as an affirmative defense to a negligence claim, the court in a nonjury action shall make findings of fact, and the jury in a jury action shall return a general verdict accompanied by answers to interrogatories, that shall specify the following:

(1) The total amount of the compensatory damages that would have been recoverable on that negligence claim but for the negligence or implied assumption of the risk of the complainant or the person for whom he is legal representative;

(2) The portion of the compensatory damages specified under division (B)(1) of this section that represents economic loss;

(3) The portion of the compensatory damages specified under division (B)(1) of this section that represents noneconomic loss;

(4) The percentage of negligence or implied assumption of the risk that directly and proximately caused the injury, death, or loss to person or property, in relation to one hundred per cent, that is attributable to the complainant or the person for whom he is legal representative, and the percentage of negligence that directly and proximately caused the injury, death, or loss to person or property, in relation to one hundred per cent, that is attributable to each party to the action from whom the complainant seeks recovery. If the court or jury must determine percentages of negligence under this division for two or more parties from whom the complainant seeks recovery and an issue of vicarious liability, including, but not limited to, liability of a principal or master for the negligent actions or omissions of an agent or servant, exists relative to those parties, then, for purposes of determining such percentages, the court in a nonjury action shall determine, or the jury in a jury action pursuant to an instruction from the court shall determine, that the parties in question are to be treated as a single party to the extent that any vicarious liability is determined to exist relative to those parties.

(C) After the court makes its findings of fact or after the jury returns its general verdict accompanied by answers to interrogatories as described in division (B) of this section, the court shall diminish the total amount of the compensatory damages that would have been recoverable by an amount that is proportionately equal to the percentage of negligence or implied assumption of the risk that is attributable to the complainant or the person for whom he is legal representative, which percentage was determined pursuant to division (B) of this section. If the percentage of the negligence or implied assumption of the risk that is attributable to the complainant or the person for whom he is legal representative is greater than the total of the percentages of the negligence that is attributable to all parties from whom the complainant seeks recovery, which percentages were determined pursuant to division (B) of this section, the court shall enter judgment in favor of those parties.

(D)(1) If contributory negligence or implied assumption of the risk is asserted as an affirmative defense to a negligence claim, if it is determined that the complainant or the person for whom he is legal representative was contributorily negligent or impliedly assumed a risk and that such contributory negligence or implied assumption of the risk was a direct and proximate cause of the injury, death, or loss to person or property in question, and if the complainant is entitled to recover compensatory damages pursuant to this section from more than one party, then, after it makes findings of fact or after the jury returns its general verdict accompanied by answers to interrogatories as described in division (B) of this section, the court shall enter a judgment that is in favor of the complainant and that states all of the following:

(a) Proportionate shares of the portion of the compensatory damages that represents noneconomic loss for each party against whom the judgment is entered and for the complainant or the person for whom he is legal representative, which shares shall be computed by multiplying the portion of the compensatory damages that represents noneconomic loss as determined pursuant to division (B)(3) of this section by the respective percentages of negligence or implied assumption of the risk as determined pursuant to division (B)(4) of this section;

(b) In relation to the portion of the compensatory damages that represents noneconomic loss as determined pursuant to division (B)(3) of this section, each party against whom the judgment is entered is liable to the complainant only for the proportionate share of that party as described in division (D)(1)(a) of this section;

(c) In relation to the portion of the compensatory damages that represents economic loss as determined pursuant to division (B)(2) of this section, each party against whom the judgment is entered is jointly and severally liable to the complainant for the entire amount of economic loss for which the complainant is entitled to judgment as determined pursuant to divisions (B)(2) and (C) of this section.

(2) Sections 2307.31 and 2307.32 of the Revised Code apply in relation to the portion of the compensatory damages that

represents economic loss and for which joint and several liability attaches under division (D)(1)(c) of this section.

(E) As used in this section:

(1) "Economic loss" means any of the following types of pecuniary harm:

(a) All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a negligence claim;

(b) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a negligence claim;

(c) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a negligence claim.

(2) "Negligence claim" means a civil action for damages for injury, death, or loss to person or property to the extent that such damages are sought or recovered based on allegation or proof of negligence.

(3) "Noneconomic loss" means nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a negligence claim, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, mental anguish, and any other intangible loss.

42 C.F.R. §401.613. Compromise of claims.

(a) Amount of compromise. HFCA requires that the amount to be recovered through a compromise of a claim must--

(1) Bear a reasonable relation to the amount of the claim; and

(2) Be recoverable through enforced collection procedures.

(b) General factors. After considering the bases for a decision to compromise a claim under paragraph (c) of this section, HCFA may further consider factors such as--

(1) The age and health of the debtor if the debtor is an individual;

(2) Present and potential income of the debtor; and

(3) Whether assets have been concealed or improperly transferred by the debtor.

(c) Basis for compromise. Bases on which HCFA may compromise a claim include the following--

(1) Inability to pay. HCFA may compromise a claim if it determines that the debtor, or the estate of a deceased debtor, does not have the present or prospective ability to pay the full amount of the claim within a reasonable time.

(2) Litigative probabilities. HCFA may compromise a claim if it determines that it would be difficult to prevail in a case before a court of law as a result of the legal issues involved or inability of the parties to agree to the facts of the case. The amount that HCFA accepts in compromise under this provision will reflect--

(i) The likelihood that HCFA would have prevailed on the legal question(s) involved;

(ii) Whether and to what extent HCFA would have obtained a full or partial recovery of a judgment, depending on the availability of witnesses, or other evidentiary support for HCFA's claim; and

(iii) The amount of court costs that would be assessed to HCFA.

(3) Cost of collecting the claim. HCFA may compromise a claim if it determines that the cost of collecting the claim does not justify the enforced collection of the full amount. In this case, HCFA may adjust the amount it accepts as a compromise to allow an appropriate discount for the costs of collection it would have incurred but for the compromise.

(d) Enforcement policy. HCFA may compromise statutory penalties, forfeitures, or debts established as an aid to enforcement or to compel compliance, if it determines that its enforcement policy, in terms of deterrence and securing compliance both present and future, is adequately served by acceptance of the compromise amount.

42 C.F.R. §411.20. Basis and scope.

(a) Statutory basis. (1) Section 1862(b)(1) of the Act precludes Medicare payments for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following:

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

(2) Sections 1862 (b)(2) and (b)(3) of the Act (omitting the word "promptly") preclude Medicare payments for services to the extent that payment has been made or can reasonably be expected to be made under an employer group health plan, with respect to a beneficiary who is under age 65 and entitled to Medicare solely on the basis of ESRD or who is age 65 or over and either employed, or the spouse of an employed individual of any age.

(b) Scope. This subpart sets forth the rules that are applicable to all or several of the types of insurance coverage that are the subject of Subparts C through F of this part.

42 C.F.R. §411.21. Definitions.

As used in this subpart and Subparts C through F of this part--"Conditional payment" means a Medicare payment for services for which another insurer is primary payer, made either on the bases set forth in Subparts C through F of this part, or because the intermediary or carrier did not know that the other coverage existed.

"Coverage" or "covered services", when used in connection with third party payments, means services for which a third party payer would pay if a proper claim were filed.

"Plan" means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

"Prompt" or " promptly", when used in connection with third party payments, except as provided in s 411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim.

"Proper claim" means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer.

"Secondary", when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare.

"Secondary payments" means payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.

"Third party payer" means an insurance policy, plan, or program that is primary to Medicare.

"Third party payment" means payment by a third party payer for services that are also covered under Medicare.

42 C.F.R. §411.23. Beneficiary's cooperation.

(a) If HCFA takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If HCFA's recovery action is unsuccessful because the beneficiary does not cooperate, HCFA may recover from the beneficiary.

42 C.F.R. §411.24. Recovery of conditional payments.

If a Medicare conditional payment is made, the following rules apply:

(a) Release of information. The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to HCFA. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(b) Right to initiate recovery. HCFA may initiate recovery as soon as it learns that payment has been made or could be made

under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

(c) Amount of recovery. HCFA may recover an amount equal to the Medicare payment or the amount payable by the third party, whichever is less. (The "amount payable by the third party" does not include the doubled portion of damages the third party may have paid under section 1862(b)(5) of the Act or any other punitive damages.)

(d) Methods of recovery. HCFA may recover by direct collection or by offset against any monies HCFA owes the entity responsible for refunding the conditional payment.

(e) Recovery from third parties. HCFA has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator.

(f) Claims filing requirements. (1) HCFA may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, HCFA will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is primary to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) Recovery from parties that receive third party payments. HCFA has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a third party payment.

(h) Reimbursement to Medicare. If the beneficiary or other party receives a third party payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) Special rules. (1) In the case of liability insurance settlements and disputed claims under employer group health plans and no-fault insurance, the following rule applies: If Medicare is not

reimbursed as required by paragraph (h) of this section, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(1) of this section also apply if a third party payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(3) In situations that involve procurement costs, the rule of s 411.37(b) applies.

(j) Recovery against Medicaid agency. If a third party payment is made to a State Medicaid agency and that agency does not reimburse Medicare, HCFA may reduce any Federal funds due the Medicaid agency (under title XIX of the Act) by an amount equal to the Medicare payment or the third party payment, whichever is less.

(k) Recovery against Medicare contractor. If a Medicare contractor, including an intermediary or carrier also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, HCFA may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

(l) Recovery when there is failure to file a proper claim--(1) Basic rule. If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a third party payer, and Medicare is unable to recover from the third party payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) Exceptions: (i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) HCFA will not recover from providers or suppliers that are in compliance with the requirements of s 489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

42 C.F.R. §411.25. Third party payer's notice of mistaken Medicare primary payment.

(a) If a third party payer learns that has made a Medicare primary payment for services for which the third party payer has made should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.

(b) The notice must describe the specific situation and the circumstances (including the particular type of insurance coverage as specified in s 411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) If a plan is self-insured and self-administered, the employer must give the notice to HCFA. Otherwise, the insurer, underwriter, or third party administrator must give the notice.

42 C.F.R. §411.26. Subrogation and right to intervene.

(a) Subrogation. With respect to services for which Medicare paid, HCFA is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer.

(b) Right to intervene. HCFA may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

42 C.F.R. §411.28. Waiver of recovery and compromise of claims.

(a) HCFA may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.

(b) General rules applicable to compromise of claims are set forth in Subpart F of Part 401 and s 405.374 of this chapter.

(c) Other rules pertinent to recovery are contained in Subpart C of Part 405 of this chapter.

42 C.F.R. §411.32. Basis for Medicare secondary payments.

(a) Basic rules. (1) Medicare benefits are secondary to benefits payable by a third party payer even if State law or the third party payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.

(2) Except as provided in paragraph (b) of this section, Medicare makes secondary payments, within the limits specified in paragraph (c) of this section and in s 411.33, to supplement the third party payment if that payment is less than the charges for the services and, in the case of services paid on other than a reasonable charge basis, less than the gross amount payable by Medicare under s 411.33(e).

(b) Exception. Medicare does not make a secondary payment if the provider or supplier is either obligated to accept, or voluntarily accepts, as full payment, a third party payment that is less than its charges.

(c) General limitation: Failure to file a proper claim. When a provider or supplier, or a beneficiary who is not physically or mentally incapacitated, receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment may not exceed the amount that would have been payable under s 411.33 if the third party payer had paid on the basis of a proper claim.

The provider, supplier, or beneficiary must inform HCFA that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

42 C.F.R. §411.37. Amount of Medicare recovery when a third party payment is made as a result of a judgment or settlement.

(a) Recovery against the party that received payment.--(1) General rule. Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement, as provided in this section, if--

(i) Procurement costs are incurred because the claim is disputed; and

(ii) Those costs are borne by the party against which HCFA seeks to recover.

(2) Special rule. If HCFA must file suit because the party that received payment opposes HCFA's recovery, the recovery amount is as set forth in paragraph (e) of this section.

(b) Recovery against the third party payer. If HCFA seeks recovery from the third party payer, in accordance with s 411.24(i), the recovery amount will be no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) Medicare payments are less than the judgment or settlement amount. If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

(1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

(2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) Medicare payments equal or exceed the judgment or settlement amount. If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

(e) HCFA incurs procurement costs because of opposition to its recovery. If HCFA must bring suit against the party that received payment because that party opposes HCFA's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

42 C.F.R. §411.50. General provisions.

(a) Limits on applicability. The provisions of this Subpart C do not apply to any services required because of accidents that occurred before December 5, 1980.

(b) Definitions.

"Automobile" means any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

"Liability insurance" means insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance.

"Liability insurance payment" means a payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.

"No-fault insurance" means insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called "medical payments coverage", "personal injury protection", or "medical expense coverage".

"Prompt" or "promptly", when used in connection with payment by a liability insurer means payment within 120 days after the earlier of the following:

(1) The date a claim is filed with an insurer or a lien is filed against a potential liability settlement.

(2) The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

"Self-insured plan" means a plan under which an individual, or a private or governmental entity, carries its own risk instead of

taking out insurance with a carrier. The term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay liability claims under the Federal Tort Claims Act.

"Underinsured motorist insurance" means insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

"Uninsured motorist insurance" means insurance under which the policyholder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law, or is underinsured.

(c) Limitation on payment for services covered under no-fault insurance. Except as provided under ss 411.52 and 411.53 with respect to conditional payments. Medicare does not pay for the following:

(1) Services for which payment has been made or can reasonably be expected to be made promptly under automobile no-fault insurance.

(2) Services furnished on or after November 13, 1989 for which payment has been made or can reasonably be expected to be made promptly under any no-fault insurance other than automobile no-fault.

42 C.F.R. §411.54. Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.

(a) Definition. As used in this section, "Medicare-covered services" means services for which Medicare benefits are payable or would be payable except for applicable Medicare deductible and coinsurance provisions. Medicare benefits are payable notwithstanding potential liability insurance payments, but are recoverable in accordance with s 411.24.

(b) Applicability. This section applies when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer for injuries or illness allegedly caused by another party.

(c) Basic rules--(1) Itemized bill. A hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

(2) Specific limitations. Except as provided in paragraph (d) of this section, the provider or supplier--

(i) May not bill the liability insurer nor place a lien against the beneficiary's liability insurance settlement for Medicare covered services.

(ii) May only bill Medicare for Medicare-covered services; and

(iii) May bill the beneficiary only for applicable Medicare deductible and coinsurance amounts plus the amount of any charges that may be made to a beneficiary under s 413.35 of this chapter (when cost limits are applied to the services) or under s 489.32 of this chapter (when services are partially covered).

(d) Exceptions--(1) Nonparticipating suppliers. The limitations of paragraph (c)(2) of this section do not apply if the services were furnished by a supplier that is not a participating supplier and has not accepted assignment for the services or has not claimed payment for them under s 424.64 of this chapter.

(2) Prepaid health plans. If the services were furnished through an organization that has a contract under section 1876 of the Act (that is, through an HMO or CMP), or through an organization that is paid under section 1833(a)(1)(A) of the Act (that is, through an HCPP) the rules of s 417.528 of this chapter apply.

(3) Special rules for Oregon. For the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, there are the following special rules:

(i) The limitations of paragraph (c)(2) of this section do not apply if the liability insurer pays within 120 days after the earlier of the following dates:

(A) The date the hospital files a claim with the insurer or places a lien against a potential liability settlement.

(B) The date the services were provided or, in the case of inpatient hospital services, the date of discharge.

(ii) If the liability insurer does not pay within the 120-day period, the hospital must withdraw its claim or lien and comply with the limitations imposed by paragraph (c)(2) of this section.